

**U.S. Department of Labor**

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**Issue Date: 06 January 2004**

***In the Matter of:***

BANNER EDISON MARSHALL,  
Claimant,

v.

GLAMORGAN COAL CORPORATION,  
Employer,

and

DIRECTOR, OFFICE OF WORKERS'  
COMPENSATION PROGRAMS,  
Party-In-Interest

CASE NO: 2002BLA5212

***Appearances:***

Joseph Wolfe, Esquire  
For the Claimant

Timothy W. Gresham, Esquire  
For the Employer

Before: EDWARD TERHUNE MILLER  
Administrative Law Judge

**DECISION AND ORDER – AWARDING BENEFITS**

Statement of the Case

This proceeding involves a subsequent claim for benefits under the Black Lung Benefits Act as amended, 30 U.S.C. §901 *et seq.* (the Act), and the regulations promulgated thereunder.<sup>1</sup>

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<sup>1</sup> The Department of Labor's amendment of the regulations implementing the Federal Coal Mine Health and Safety Act of 1969 became effective on January 19, 2001, and were published at 65 Fed. Reg. 80,045-80, 107 (2000)(codified at 20 CFR Parts 718, 722, 725, and 726 (2003)). Citations to the regulations, unless otherwise indicated, refer to the amended regulations. The Director's exhibits are denoted "D-"; Claimant's exhibits, "C-"; Employer's exhibits, "E-"; and citations to the transcript of the hearing, "Tr."

Since Claimant filed this application for benefits after March 31, 1980, Part 718 applies. This claim is governed by the law of the Fourth Circuit of the United States since Claimant was last employed in the coal industry in West Virginia. *See Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (*en banc*). Because the claim was filed after January 19, 2001, the amended regulations in Parts 718 and 725 apply.

Banner E. Marshall ("Claimant") filed a claim for benefits under the Act on February 6, 1973 (D-1). On April 1, 1978, Claimant requested that the Department of Labor review the claim, and the District Director denied benefits on December 11, 1979 (D-1).

Claimant filed a subsequent claim for benefits on December 31, 1981 (D-2). The District Director denied the claim on February 10, 1983 (D-2). Claimant filed a second subsequent claim on June 23, 1986, which was denied by the Director on December 2, 1986 (D-3). Claimant appealed the denial on January 26, 1987 (D-3). Ultimately, Administrative Law Judge Paul H. Teitler denied benefits in a Decision and Order dated June 16, 1992, because Claimant had not proved any of the elements necessary to establish entitlement (D-3). Claimant appealed on June 29, 1992, and in a Decision and Order dated August 26, 1993, the Benefits Review Board affirmed. (D-3) Claimant filed a motion for reconsideration on September 24, 1993, which was denied by the Benefits Review Board on January 25, 1996 (D-3).

Claimant submitted a timely request for modification on November 19, 1996, and in a Proposed Decision and Order dated April 1, 1997, the Director denied the request (D-3). Claimant requested a hearing before an administrative law judge on April 23, 1997 (D-3). In a Decision and Order dated February 2, 1999, Administrative Law Judge Richard A. Morgan denied the request for modification because, while Claimant had proved that he had pneumoconiosis related to his coal mining employment, Claimant had not proved that he was totally disabled or that the disability was caused by pneumoconiosis (D-3). Claimant appealed on February 5, 1999, and in a Decision and Order dated February 25, 2000, the Benefits Review Board affirmed (D-3).

Claimant filed a third subsequent claim for benefits on March 1, 2001 and in a Proposed Decision and Order Dated March 6, 2002, the Director awarded benefits (D-5, 32). On March 21, 2002, Glamorgan Coal Corporation (the "Employer"), which is self-insured, requested a hearing before an administrative law judge (D-35). A hearing took place before this tribunal on May 14, 2003, in Abingdon, Virginia.

### **ISSUES**

1. What evidence offered by the parties is properly admitted into the evidentiary record pursuant to applicable regulations?
2. Whether, under §725.309, Claimant has shown a change in applicable conditions of entitlement since the previous denial of benefits on February 25, 2000, by establishing that he is totally disabled by a respiratory or pulmonary impairment?

3. If so, whether Claimant has established the elements of entitlement to benefits under Part 718?

### FINDINGS OF FACT

#### Background

Claimant was born on October 13, 1944, and completed seven years of formal education (D-5). Claimant alleged that he completed twenty-four and a half years of coal mine employment, ending in 1986 (D-5, 6). Employer stipulated to twenty-three years of coal mine employment, which the record supports, and this tribunal so finds (D-10, Tr. 19). Claimant last worked in the coal mining industry for Employer as an extra foreman, a section foreman, and a belt inspector performing heavy manual labor (D-8, Tr. 56, 58-60). Claimant married Beulah Marshall on September 25, 1964, and they were married at the time of the hearing (D-5, 12, Tr. 65, 66).

#### Medical Evidence Developed Subsequent to the Closing of the Record on Which the Prior Denial was Based

#### Admissible New Evidence

Director's Exhibits 1-42 were identified and offered into evidence in accordance with §725.421, but by oversight were not formally admitted into evidence at the hearing. Since both parties indicated at the hearing that they did not object to the admission of these identified documents, except for Employer's objection to the admissibility of two specific x-ray interpretations included in D-16, the Director's Exhibits 1-42 are deemed to have been admitted into the evidentiary record, subject to Employer's objection, as they properly should have been, without objection, *nunc pro tunc*, as D-1-42. (Tr. 6-7)

Employer's objection to the admission into evidence of the two particular x-ray interpretations included in D-16 as it was originally submitted by Claimant pertained to the reading by Dr. DePonte of a November 27, 2000, x-ray film, and the reading by Dr. Patel of a February 12, 2001, x-ray film, as part of Dr. Rasmussen's examination used as the basis of one of Claimant's medical reports. Employer contended that the two x-rays should be counted against the limitation of two x-rays under §725.414(a)(2)(i), because they were evidence developed after the previous denial of benefits on February 25, 2000 (D-16; Tr. 6-8, 10, 12). Also, Claimant had identified two other x-rays in his evidence summary form, the reading by Dr. DePonte of a May 21, 1997, x-ray film, and the reading by Dr. Robinette of a January 2, 2003, x-ray film (C-1, 2). Claimant contended that evidence included in the Director's exhibits which was developed before he filed his current claim should not be subject to the limitations prescribed §725.414(a) (Tr. 9-12).

This tribunal ruled that evidence developed after the close of the prior claim is subject to the constraints of §725.414(a), regardless of when the subsequent claim is filed (Tr. 13-15). Since Claimant elected to submit two other x-rays pursuant to the constraints of §725.414(a)(2)(i), Employer's objection to the admission of the interpretations of Dr. DePonte

and Dr. Patel included in D-16 is sustained and the two readings are excluded from evidence because Claimant did not otherwise establish their admissibility for any allowable purpose. The issue of the extent to which these x-rays could be properly mentioned by Dr. Robinette in his testimony was resolved by self-imposed limits to the scope of Claimant's inquiry at the hearing and Respondent's perception of the proper scope of pertinent inquiry (Tr. 15-19). Claimant's Exhibit 1, Dr. DePonte's reading of the x-ray dated May 21, 1997, and CT scan dated December 14, 2000; and Claimant's Exhibit 2, Dr. Robinette's report, including his reading of the x-ray dated January 2, 2003; have been admitted into evidence in support of Claimant's affirmative case in accordance with Claimant's evidence summary form, referred to by the parties, but not formally in evidence. Dr. Robinette's testimony at the hearing is deemed to have been that of a physician who prepared a medical report admitted into evidence under §725.414(c).

Employer objected to the admissibility of Claimant's Exhibit 3, Dr. DePonte's deposition, at the hearing, because Dr. DePonte made readings of chest x-rays in the course of her deposition testimony beyond the applicable limitations of §725.414(a)(2)(i). In its brief, Employer elaborated upon its objection made at the hearing. In response to Employer's initial objections at the hearing, Claimant resubmitted and substituted the deposition in redacted form with his brief (Tr. 68-83, 87-88, 92, 97, 100, 102). Employer contends in its brief, however, that Dr. DePonte's deposition, even as redacted, is inadmissible. Employer contends that Dr. DePonte's interpretations of the x-ray and CT scan in C-1 do not qualify as reports under §725.414(a)(1), because a physician's written assessment of a single objective test is explicitly disqualified as such by §725.414(a)(1), and that Dr. DePonte's deposition testimony would not be allowable because it does not qualify as a report under §725.414(c). In the alternative, Employer contends that, if the deposition were deemed to qualify as, or in lieu of, a medical report, it would be barred under §725.414(c) as in excess of Claimant's quota of two medical reports, since Claimant has elected to rely upon the medical reports of Dr. Rasmussen and Dr. Robinette. Employer also contends that there is no rebuttal or rehabilitative evidence in the deposition. Claimant did not refer to or rely upon Dr. DePonte's deposition for any purpose in his brief, and neither answered nor rebutted Employer's contentions regarding it, other than to assert at the hearing that it was relied upon as rehabilitative evidence.

Employer's points are well taken, and the deposition of Dr. DePonte, C-3, even as redacted, should be, and is, excluded in its entirety. It is not admissible as an elaboration of a report in evidence pursuant to §725.414(c), because Dr. DePonte's x-ray and CT scan interpretations admitted as C-1 do not qualify as medical reports under §725.414(a)(1). Nor is it admissible in lieu of a report under §725.414(c), because Claimant is limited to Dr. Rasmussen's and Dr. Robinette's reports which he separately designated. §725.414(a)(2)(ii). Dr. DePonte's deposition is nowhere designated by Claimant as rebuttal evidence, and, as pointed out by Employer, it contains no such evidence in its redacted form. Dr. DePonte's deposition is not admissible as rehabilitative evidence under §725.414(a)(2)(ii) because it does not qualify as "an additional statement from the physician who originally . . . administered the objective testing" with respect to rebuttal evidence adduced by Employer "submitted with respect to medical testing submitted by the claimant" tending "to undermine the conclusion of a physician who prepared a medical report submitted by the claimant." Nor does it purport to explain Dr. DePonte's conclusion in light of the rebuttal evidence, as required by the regulation, since Dr. DePonte's reading of the May 21, 1997, x-ray was not rebutted, and the testimony on deposition

did not address Dr. Wheeler's review of the December 14, 2000, CT scan submitted by Employer as rebuttal (E-18). Moreover, Dr. DePonte's reading shows that Dr. Tholpady, not Dr. DePonte "administered" the CT scan (C-1).

Although Dr. Robinette's report was the only medical report designated by Claimant in his evidence summary form under §724.414(a)(2)(i), Claimant relied in his brief upon Dr. Rasmussen's report dated February 12, 2001, included in DX 16. That report was generated subsequent to the prior denial of benefits as of February 25, 2000, and referred to the x-ray reading by Dr. Patel, which has been excluded. Employer did not object to admission of Dr. Rasmussen's report when he objected to the x-rays included in DX-16, though his objection to Dr. Patel's x-ray would implicitly extend to Dr. Rasmussen's reference to the x-ray in his report. Employer also seemed to assume that Claimant would rely upon Dr. Rasmussen's report (Tr. 6-7). It was apparent at the hearing that Claimant's attorney was under the misapprehension that evidence generated after the prior denial of benefits, but prior to Claimant's filing the pending subsequent claim, could be relied upon as part of the record to prove Claimant's case without the limitations under §725.414(a)(2)(i), and so on that theory Dr. Rasmussen's report would not have been designated in the evidence summary form. Although Claimant identified only Dr. Robinette's medical report in his evidence summary form, the report by Dr. Rasmussen is deemed to be properly considered part of the evidentiary record developed by Claimant within the constraints of §725.414(a)(2)(i) because of its implicit designation in Claimant's brief. Likewise, the pulmonary function studies and arterial blood gas studies, though not the x-ray interpretation, reported by Dr. Rasmussen, may be relied upon by Claimant under the applicable regulatory limits.

Exhibits 1-10 were identified by Employer's counsel as having been received in evidence in prior proceedings, but omitted from the record transmitted pursuant to §725.421. Their admission into evidence was deferred at the hearing, subject to confirmation of the alleged omissions (Tr. 89-92). There has been no objection or contest of Employer's representations in regard thereto. However, in its brief, Employer stated that it could find mention of only five of the exhibits in any prior decisions, i.e. E-3-5, 7-8, and so Employer has moved the admission of those exhibits, and withdrawn Exhibits 1, 2, 6, 9, and 10. E-3-5, 7-8, therefore, are admitted into evidence, *nunc pro tunc*. Employer's Exhibits 15, 18, 19, were admitted into evidence; 11-14, 16-17 were withdrawn (Tr. 92-102).<sup>2</sup>

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<sup>2</sup> Neither party has taken exception to the post evidentiary changes or sought to file a responsive brief.

### X-rays<sup>3</sup>

Exhibit No.	X-ray Date	Physician	Qualifications	Film Quality	Interpretation
C-1	5/21/97	DePonte	R/B	2	2/1 p/r, B sized large opacities
D-31	9/17/01	Hippensteel	B	2	1/2, q/p, B(?) sized large opacities
E-15	10/30/02	Wheeler <sup>4</sup>	R/B	3	0/0 <sup>5</sup>
C-2	1/2/03	Robinette	B	1	2/3, q/r, B sized large opacities

### Pulmonary Function Studies<sup>6</sup>

Exh. No	Test Date	Age/ Ht	Doctor	Co-op./ Undst./ Conf.?	FEV1	FVC	MVV	Qualify
D-16	2/12/01	56/ 67"	Rasmussen	Not Noted/ No	2.82 2.96	4.16 4.19	114 121	No No
D-31	9/17/01	56/ 67"	Hippensteel	Not Noted/ No	2.43 2.52	3.24 3.37	74 -	No No

<sup>3</sup> The following abbreviations are used in describing the qualifications of the physicians: B-reader, "B"; board-certified radiologist, "R". An interpretation of "0/0" signifies that the film was read as completely negative for pneumoconiosis. Dr. DePonte's May 8, 2001, reading of an x-ray dated May 21, 1997 is not probative of a change in conditions and was not reviewed as part of the evidence submitted with the pending claim.

<sup>4</sup> This tribunal has taken judicial notice of Dr. Wheeler's qualifications by reference to the worldwide web, American Board of Medical Specialties, Who's Certified Results, at <http://www.abms.org>, and the List of NIOSH Approved B Readers, found, *inter alia*, at <http://www.oalj.dol.gov/libbla.htm>. See *Maddaleni v. Pittsburgh & Midway Coal Mining Co.*, 14 B.L.R. 1-135 (1990).

<sup>5</sup> Noted oval 6 x 3 cm. mass subapical that was compatible with conglomerate tuberculosis more likely than a tumor.

<sup>6</sup> The second set of values indicates post-bronchodilator studies.

<b>Exh. No</b>	<b>Test Date</b>	<b>Age/ Ht</b>	<b>Doctor</b>	<b>Co-op./ Undst./ Conf.?</b>	<b>FEV1</b>	<b>FVC</b>	<b>MVV</b>	<b>Qualify</b>
E-15	10/30/02	58/ 66” <sup>7</sup>	Dahhan	Good/ Good/ Yes	2.71	3.70	43	No
C-2	1/2/03	58/ 66”	Robinette	Good/ Good/ No <sup>8</sup>	2.67	3.65	-	No

#### Arterial Blood Gas Studies<sup>9</sup>

<b>Exh. No.</b>	<b>Test Date</b>	<b>Physician</b>	<b>Conform?</b>	<b>pCO2</b>	<b>pO2</b>	<b>Qualifying</b>
D-16	2/12/01	Rasmussen	Yes	33	87	No
				30	90	No
D-31	9/17/01	Hippensteel	No <sup>10</sup>	35.4	84.9	No
				33.6	82	No
E-15	10/30/02	Dahhan	Yes	38.4	88.9	No
				36	100.7	No
C-2	1/2/03	Robinette	No <sup>11</sup>	29	110	No

<sup>7</sup> The original measurement was 169 centimeters.

<sup>8</sup> Three tracings not present.

<sup>9</sup> The second set of entries indicates results after exercise.

<sup>10</sup> No altitude or barometric pressure recorded.

<sup>11</sup> No altitude or barometric pressure recorded.

### CT Scan Reports

<b>Exh.</b>	<b>Ct Scan Date</b>	<b>Physician/ Qualifications</b>	<b>Interpretation</b>
C-1	12/14/00	DePonte/ R/B	5 x 2 cm. right apical mass. The configuration and appearance of this is entirely consistent with a conglomerate mass from pneumoconiosis. A lung carcinoma cannot be entirely excluded. Diffuse parenchymal interstitial abnormalities consistent with pneumoconiosis.
E-18	12/14/00	Wheeler/ R/B	10 mm thick lung and mediastinal settings: unchanged except technique since 4/11/00. No pneumoconiosis. Oval well defined 6 cm wide and 3 cm thick mass in posterior subapical right upper lung contains tiny calcified granulomata in its medial portion and involves upper oblique fissure. Few linear scars extend from mass to adjacent pleura. Few tiny linear scars and nodules in posterolateral subapical left upper lung compatible with TB unknown activity probably healed.

### Medical Reports and Opinions

#### *Dr. Donald L. Rasmussen*

In connection with a medical report dated February 12, 2001, Dr. Rasmussen, who is board-certified in internal medicine and is a B-reader, examined Claimant. Dr. Rasmussen noted that Claimant started smoking in 1960 and smoked an average of one pack of cigarettes a day until he quit in 1996. Dr. Rasmussen noted that Claimant worked in the coal mines for twenty-four and one half years, last working as a section foreman, performing “considerable” heavy manual labor, and stopped working in 1986. Claimant’s ventilatory function studies revealed a slight, irreversible obstructive insufficiency and the maximum breathing capacity was normal. Dr. Rasmussen opined that the resting blood gases were normal. Dr. Rasmussen concluded that overall, the studies indicated no significant loss of lung function and that Claimant retained the pulmonary capacity to perform his last regular coal mine job. Dr. Rasmussen opined that neither the patient’s coal mine dust exposure, nor his cigarette smoking have produced significant loss of lung function. Dr. Rasmussen concluded that based upon an x-ray by Dr. Patel, that Claimant had complicated pneumoconiosis. However, this x-ray was not admitted into the record, because Claimant chose to submit other x-rays into evidence as governed by the amended regulations, and so this portion of Dr. Rasmussen’s opinion is given no weight. (D-16).

#### *Dr. Kirk E. Hippensteel*

In connection with his medical report dated October 5, 2001, Dr. Hippensteel, who is board-certified in internal medicine and the subspecialty of pulmonary disease and is a B-reader,

examined Claimant and reviewed specified medical evidence. (D-31) Dr. Hippensteel noted that Claimant worked in the coal mines for twenty-four and a half years, quitting in 1986, and last worked as a section foreman, which included walking and lifting fifty pound rock dust bags. He also noted that Claimant smoked about one pack of cigarettes per day for a total of thirty-four years, until he stopped seven or eight years before the examination. After examining Claimant, Dr. Hippensteel opined that, although the radiographic findings from the examination suggest the possibility of simple and possibly complicated CWP, Claimant's pulmonary function test findings, including diffusing capacity, and resting and exercise arterial blood gas studies are against complicated pneumoconiosis, since the tests were in a normal range and not indicative of progressive massive fibrosis referable to severe advance effects of coal dust inhalation. Dr. Hippensteel opined that Claimant does not have any pulmonary dysfunction, and that the evidence strongly indicated against a diagnosis of complicated CWP because complicated pneumoconiosis regularly causes impairment in pulmonary function. Dr. Hippensteel opined that the small rounded opacities seen on Claimant's chest x-ray and CT scan could be from granulomatous disease "which [had] produced more localized intense inflammation" and had not created changes in pulmonary function referable to "this process." Dr. Hippensteel opined that tuberculosis, histoplasmosis, and sarcoidosis are all types of granulomatous disease. Dr. Hippensteel opined that the lack of findings on blood tests for histoplasmosis and sarcoidosis do not rule them out, and a negative skin test for tuberculosis does not rule it out completely. However, he opined that tuberculosis, if it were untreated, would cause progressive changes in function, which has not been the case in Claimant.

After reviewing specified medical evidence, Dr. Hippensteel opined that, in spite of radiographic findings and pathology findings, Claimant has not developed changes consistent with more than simple pneumoconiosis, and that it does not appear that the simple pneumoconiosis is in a severe stage. Dr. Hippensteel opined that the rounded opacities on Claimant's chest x-rays and CT scan may be predominantly secondary to granulomatous disease that has caused the development of a large lesion in his right upper lobe. Dr. Hippensteel opined that the normal pulmonary function studies and blood gases in Claimant showed that the findings in his lungs were more localized and less inflammatory than could be expected if the findings actually represented complicated CWP. Dr. Hippensteel opined that even though a specific diagnosis had not been made in Claimant, the findings were much more compatible with some type of noninfectious or infectious granulomatous disease, which had become quiescent by his own body defenses, rather than complicated pneumoconiosis, since granulomatous disease can create significant lesions on a chest x-ray without significant impairment in function. He declared that such a process would be very unusual for complicated pneumoconiosis. Dr. Hippensteel opined that complicated pneumoconiosis or progressive massive fibrosis is regarded as a disabling disease, and because the pulmonary function is expected to be routinely affected by such a disease, which did not occur, Dr. Hippensteel strongly disagreed with such a diagnosis of Claimant's condition. (D-31).

In a deposition taken on April 24, 2003, Dr. Hippensteel opined that the CT Scans "favored" a finding of a granulomatous lesion in Claimant's right upper lobe, and that it was not possible to separate out all of the other small lesions as being granulomatous or simple CWP, because the patterns of those individual small lesions were similar, "especially when they are not calcified." (E-19) Dr. Hippensteel opined that he could not rule out a finding of simple CWP.

However, he opined that the large opacity was not complicated CWP because its calcification and pattern strongly favored granulomatous disease over CWP. Dr. Hippensteel opined that the lack of small opacities of CWP in Claimant's left lung indicated that there was no complicated CWP. In addition, Dr. Hippensteel opined that because the lesion grew quickly in 1998 and has not continued to grow in size, it is not complicated CWP, which usually progresses in size. Dr. Hippensteel opined that Claimant did not have a respiratory impairment that would prevent him from returning to his last coal mine employment. Dr. Hippensteel concluded that Claimant had simple CWP, not complicated CWP. Dr. Hippensteel opined that Claimant had a localized process that was associated with finding atypical mycobacterium on culture, which is a known cause for such a calcified lesion, as is common to granulomatous disease. Dr. Hippensteel opined that the negative tuberculosis skin test did not exclude a diagnosis of granulomatous disease, because that disease does not create a positive skin test for tuberculosis. Dr. Hippensteel opined that granulomatous disease does not affect the lungs in the same way as complicated CWP, which is why Claimant was not totally disabled. (E-19).

*Dr. Emory Robinette*

In connection with a medical report dated January 2, 2003, Dr. Robinette, who is board-certified in internal medicine and the subspecialty of pulmonary disease, and is a B-reader, reviewed specified medical evidence. Dr. Robinette noted that Claimant had worked in the coal mines as a roof bolter and continuous mine operator, and that Claimant smoked a half pack of cigarettes a day, quitting in 1996, and has a twenty pack year smoking history. Dr. Robinette diagnosed Claimant with complicated CWP with progressive massive fibrosis with a reduction of diffusion capacity secondary to the complicated CWP. Dr. Robinette noted that he has followed Claimant's health since 1987 and has seen him on a regular basis since the 1990s.

Dr. Robinette opined that a 1998 CT scan clearly demonstrated evidence of nodular interstitial disease consistent with silicosis and a six centimeter mass in the apical region of the right upper lobe with multiple foci calcification consistent with conglomerate pneumoconiosis. He opined that there has been evidence of progression of radiographic abnormalities with an initial x-ray showing a general profusion abnormality of 1/0, but subsequent x-rays demonstrating marked progression of the profusion abnormalities with a 1997 x-ray documenting a category A mass and a general profusion of 2/2, and that there has been "marked interval enlargement of the pulmonary mass with associated fibrotic reaction." He noted that a 2003 x-rays revealed a four to five centimeter mass with pleural thickening in Claimant's right upper lobe. Dr. Robinette opined that Claimant's complicated CWP was a direct consequence of his coal mining employment, and that there has been progressive scarring and distortion of Claimant's pulmonary parenchyma and the interval development of complicated pneumoconiosis over the past ten years prior to the report. Dr. Robinette concluded that Claimant is totally disabled from working in and around the coal mining area because of his radiographic abnormalities and that his condition is chronic and progressive in nature. Dr. Robinette opined that there was no evidence of any atypical infection which would explain his clinical presentation. (C-2).

Dr. Robinette testified during the May 14, 2003 hearing, that he had been tracking the size of lesions in Claimant's lungs from 1998 to present. He opined that the size of the lesions

had stabilized more recently, which ruled out the possibility of a malignancy, which would have continued to grow. Dr. Robinette opined that Claimant had complicated pneumoconiosis based on the evolution of a large opacity in Claimant's lungs, super-imposed on a background of pneumoconiosis. Dr. Robinette ruled out the possibility that Claimant had tuberculosis, histoplasmosis, sarcoidosis, and granulomatous disease based on several tests, x-ray readings, and Claimant's health. Dr. Robinette opined that, while it is unusual for Claimant to have relatively normal lung function, it is not unprecedented. Dr. Robinette opined that Claimant was totally disabled from returning to coal mine employment based on his severe "x-ray abnormality" where there is progressive massive fibrosis superimposed on a background of pneumoconiosis. Dr. Robinette opined that his role as Claimant's treating pulmonary physician allowed him to diagnose Claimant more accurately. Dr. Robinette concluded that Claimant was totally disabled based on his radiographic findings and an abnormal ventilatory response. (Tr. 21-54).

*Dr. A. Dahhan*

In connection with a medical report dated November 20, 2002, Dr. Dahhan, who is board-certified in internal medicine and the subspecialty of pulmonary disease and is a B-reader, examined Claimant and reviewed specified medical evidence. Dr. Dahhan noted that Claimant worked in the mining industry for twenty-four and a half years as a continuous miner and roof bolter, and stopped working in 1986. He also noted that Claimant used to smoke a pack of cigarettes per day, beginning at the age of sixteen and quit at the age of fifty-two, six years prior to the examination. Dr. Dahhan opined that a rounded opacity seen in the lung was "highly suspicious" for bronchogenic carcinoma or possible old tuberculosis infection, but he could not rule out the possibility of a large opacity. Dr. Dahhan opined that although the Claimant's chest x-ray could be read for complicated CWP, based on the opinions of pathologists who reviewed a biopsy of Claimant's lungs, Claimant only had simple CWP and not complicated CWP. From a respiratory standpoint, Dr. Dahhan opined that Claimant had no evidence of any respiratory impairment and/or disability as demonstrated by the examination and tests. Dr. Dahhan opined that the lack of abnormalities usually associated with complicated pneumoconiosis supported his opinion that Claimant did not have complicated CWP. Dr. Dahhan opined that Claimant's hypertension, post aortic valve replacement, peptic ulcer disease, and lower back pain were not caused by, related to, contributed to, or aggravated by the inhalation of coal dust or CWP. (E-15).

## CONCLUSIONS OF LAW AND DISCUSSION

### Proof of Entitlement

Benefits under the Act are awardable to persons who are totally disabled due to pneumoconiosis within the meaning of the Act. For the purpose of the Act, pneumoconiosis, commonly known as black lung, means a chronic dust disease of the lung, and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment. A disease arising out of coal mine employment includes any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment. §718.201. In order to obtain federal black lung benefits, a

claimant must prove by a preponderance of the evidence that: “(1) he has pneumoconiosis; (2) the pneumoconiosis arose out of his coal mine employment; (3) he has a totally disabling respiratory or pulmonary condition; and (4) pneumoconiosis is a contributing cause to his total respiratory disability.” *Milburn Colliery Co. v. Hicks*, 138 F.3d 524, 21 B.L.R. 2-323 (4th Cir. 1998); *see Dehue Coal Co. v. Ballard*, 65 F.3d 1189, 1195, 19 B.L.R. 2-304 (4th Cir. 1995); 20 C.F.R. §§718.201-204 (1999); *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986).

### Subsequent Claim

Since the instant claim was filed more than one year after the denial of Claimant’s previous claim, it is considered a subsequent claim under the Act. §725.309. Under the amended regulations, a subsequent claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final. §725.309(d). To prove that one of the applicable conditions of entitlement has changed, a claimant must prove at least one of the elements previously adjudicated against him, based on newly submitted probative medical evidence of his condition not available at the time of the prior claim. *Lisa Lee Mines v. Director, OWCP*, [Rutter], 86 F.3d 1358, 20 B.L.R. 2-227 (4th Cir. 1996) (*en banc*). In the instant claim, the previous denial was based on the finding that Claimant had not proved that he was totally disabled by a pulmonary or respiratory impairment. Therefore, in order to establish a change in conditions, Claimant must establish that he is totally disabled by a pulmonary or respiratory impairment.

### Total Disability Caused by a Pulmonary or Respiratory Impairment

To establish total disability, Claimant must prove that he is unable to engage in either his usual coal mine work or comparable and gainful work as defined in §718.204. Section 718.204(b)(2) provides the criteria for determining whether a miner is totally disabled. These criteria are: (1) pulmonary function tests qualifying under applicable regulatory standards; (2) arterial blood gas studies qualifying under applicable regulatory standards; (3) proof of pneumoconiosis and cor pulmonale with right sided congestive heart failure; or (4) proof of a disabling respiratory or pulmonary condition on the basis of the reasoned medical opinions of a physician relying upon medically acceptable clinical and laboratory diagnostic techniques. If there is contrary evidence in the record, all the evidence must be weighed in determining whether there is proof by a preponderance of the evidence that the miner is totally disabled by pneumoconiosis. *Shedlock v. Bethlehem Mines. Corp.*, 9 B.L.R. 1-95 (1986).

The fact-finder must determine the reliability of a pulmonary function study or an arterial blood gas study based upon conformity to the applicable quality standards, and must consider the medical opinions of record regarding reliability of a particular study. *Robinette v. Director, OWCP*, 9 B.L.R. 1-154 (1986); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). None of the pulmonary function studies that Claimant underwent in connection with the pending claim produced a qualifying result. Thus, the pulmonary function studies do not prove that Claimant is totally disabled by a pulmonary or respiratory impairment. Since no studies were submitted that contradict this finding, the preponderance of the pulmonary function study evidence does not establish total disability pursuant to §718.204(b)(2)(i).

Under §718.204(b)(2)(ii), arterial blood gas studies conducted before and after exercise must be weighed when reviewing relevant evidence. *Sturnick v. Consolidation Coal Co.*, 2 B.L.R. 1-972 (1982). None of the blood gas studies which were performed produced qualifying results, before or after exercise, or prove that Claimant was totally disabled by a pulmonary or respiratory impairment, or disabled pursuant to §718.204(b)(2)(ii). Since there is no evidence of cor pulmonale with right-sided congestive heart failure, Claimant has not proved total disability pursuant to §718.204(b)(2)(iii).

Pursuant to §718.104(d), this tribunal is required to give consideration to the relationship between a miner and any treating physician whose report is admitted into the record. Section 718.104(d)(5) further provides that, in appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudicating officer's decision to give that physician's opinion controlling weight, provided that the weight also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence, and the record as a whole. Dr. Robinette stated in his reports that he had been treating Claimant every six months starting in 1998 up until 2003, and testified that he was Claimant's treating physician (Tr. 37). Employer concedes that Dr. Robinette was a treating physician (Empl. Brief at 21). No evidence was introduced that would prove otherwise. Therefore, Dr. Robinette is considered Claimant's treating physician.

Dr. Robinette opined that Claimant was totally disabled by a pulmonary disease based on radiographic findings and an abnormal pulmonary process. However, Dr. Robinette did not reconcile the nonqualifying pulmonary function and arterial blood gas studies performed as part of his examination or the essentially normal findings by Dr. Rasmussen to whom he had referred Claimant for testing with his finding of an abnormal pulmonary process. Dr. Robinette relied on a finding of total disability based on x-ray findings, which is not a basis for proving disability except in relation to the irrevocable presumption under §725.304. Dr. Rasmussen, on the other hand, opined that Claimant had no significant loss of lung function and that Claimant retained the pulmonary capacity to perform his last regular coal mine job. In addition, he opined that Claimant's coal mine dust exposure and cigarette smoking have not produced significant loss of lung function. He found that Claimant had complicated pneumoconiosis, but this finding was based on an x-ray that was not admitted into the record, and he did not opine that Claimant was totally disabled by the complicated pneumoconiosis. Therefore, his opinion with regard to the existence of complicated pneumoconiosis is without probative value. As a consequence, Claimant's evidence was divided in regard to the existence of a disabling pulmonary impairment, and seriously flawed with respect to the existence of complicated pneumoconiosis.

In contrast, Dr. Hippensteel opined in a reasoned report that Claimant was not totally disabled, a conclusion supported by Dr. Dahhan's opinion. Drs. Hippensteel, Robinette, and Dahhan are board-certified in internal medicine and the subspecialty of pulmonary disease. Dr. Rasmussen is board-certified in internal medicine. Drs. Hippensteel and Dahhan are better qualified than Dr. Rasmussen because they are board-certified in pulmonary disease, and, while Dr. Robinette is equally qualified, and is also considered the treating physician, he apparently based his finding of total disability on radiographic findings, without regard to the nonqualifying objective test results. Because Drs. Hippensteel, Dahhan, and Rasmussen all opined that

Claimant had the pulmonary capacity to perform his last coal mine job, and none of the physicians, aside from Dr. Robinette, who seemingly relied only upon radiographic findings of complicated pneumoconiosis and the irrebuttable presumption, found that Claimant was totally disabled. Claimant has not established by a preponderance of the evidence that he is totally disabled by a respiratory or pulmonary impairment as required under §718.204(b)(2)(iv). Thus, the record reflects no change in an applicable condition of entitlement in this regard.

#### Complicated Pneumoconiosis – Change in Applicable Conditions of Entitlement

Pursuant to §718.304 complicated pneumoconiosis may be found on the basis of x-ray evidence of opacities greater than one centimeter in diameter, or by biopsy and/or autopsy evidence showing massive lesions in the lungs, or by means other than the previous two, so long as the means constitute acceptable medical procedure and could reasonably be expected to yield similar results, that is, an opacity greater than one centimeter in diameter or a massive lung lesion.<sup>12</sup> The Benefits Review Board has held that CT scan evidence should be considered under §718.304(c). See *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991)(*en banc*). After determination of whether the relevant evidence in each category under §718.304(a)-(c) tends to establish the existence of complicated pneumoconiosis, the evidence of all three categories must be weighed together before determining whether invocation of the irrebuttable presumption pursuant to §718.304 is justified. *Lester v. Director, OWCP*, 993 F.2d 1143, 17 B.L.R. 2-114 (4th Cir. 1993); *Melnick, supra*. A finding that a claimant has established the existence of complicated pneumoconiosis, and thus established invocation of the irrebuttable presumption of total disability due to pneumoconiosis pursuant to §718.304(a)-(c) makes it unnecessary to determine whether the evidence establishes total disability and causation. See *Eastern Assoc. Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250, 256, 22 B.L.R. 2-93, 2-100 (4th Cir. 2000); *Double B Mining, Inc. v. Blankenship*, 177 F.3d 240, 243, 22 B.L.R. 2-554, 2-560 (4th Cir. 1999); *Lester, supra*; *Melnick, supra*.

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<sup>12</sup> Section 718.304 provides in relevant part:

There is an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis..., if such miner is suffering or suffered from a chronic dust disease of the lung which: (a) When diagnosed by chest X-ray...yields one or more large opacities (greater than 1 centimeter in diameter) and would be classified in Category A, B, or C...; or (b) When diagnosed by biopsy or autopsy, yields massive lesions in the lung; or (c) When diagnosed by means other than those specified in paragraphs (a) and (b) of this section, would be a condition which could reasonably be expected to yield the results described in paragraph (a) or (b) of this section had diagnosis been made as therein described: *Provided, however*, That any diagnosis made under this paragraph shall accord with acceptable medical procedures.

See *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250, 256, 22 B.L.R. 2-93, 2-100 (4th Cir. 2000); *Double B. Mining, Inc. v. Blankenship*, 177 F.3d 240, 243, 22 B.L.R. 2-554, 2-560 (4th Cir. 1999); *Lester v. Director, OWCP*, 993 F.2d 1143, 17 B.L.R. 2-114 (4th Cir. 1993); *Melnick, supra*.

Judge Morgan's January 29, 1999, decision and order denying Claimant's request for modification and benefits establishes the bench mark for comparison related to the change in applicable conditions of entitlement that Claimant has sought to prove (D-3).<sup>13</sup> Judge Morgan found the existence of simple pneumoconiosis, but not complicated pneumoconiosis, and a failure of proof as to total disability due to pneumoconiosis. Appendix A to Judge Morgan's opinion contains a summary of x-ray evidence submitted in connection with the request for modification, which he denied, including interpretations of x-rays from 1991 to 1999. Judge Morgan noted that the new evidence before him consisted of nineteen readings of fifteen x-rays. Significantly, none of these readings identified large opacities which could be classified as large size A or B opacities, and, indeed, Judge Morgan found that the x-ray evidence was insufficient to establish the existence of pneumoconiosis. However, he found that biopsy evidence established simple, but not complicated, coal workers' pneumoconiosis.

Judge Morgan found the somewhat inconsistent interpretations by Dr. Robinette, Dr. Fishman, and Dr. Wheeler, of a June 5, 1998, CT scan did not establish the existence of complicated coal workers' pneumoconiosis. Dr. Robinette described a 6 cm. mass; Dr. Fishman, a 1.5 cm. mass; and Dr. Wheeler, a mass of unspecified size, which he described as related to an inflammatory process such as tuberculosis. Dr. Hippensteel, who did not opine in the record before Judge Morgan, and Dr. Robinette have opined that there was evidence of a five to six centimeter mass present in Claimant's lungs in 1998, prior to the last denial, but Judge Morgan did not so find, since he did not credit certain evidence in the record before him. Consequently, the existence of the five to six centimeter mass has not previously been established. Judge Morgan also found that there was not a preponderance of physicians' opinions by pathologists, or those otherwise qualified, which established complicated pneumoconiosis.

Employer contends that Claimant has not proved a change in the size of the opacity, or that he is totally disabled by pneumoconiosis, and contends that the opacity presently reflects the same mass that existed in the miner's lung when Judge Morgan concluded that it was not due to pneumoconiosis, or complicated pneumoconiosis, but to a previous inflammatory process, in 1999. Employer contends that this subsequent claim merely shows that the mass still exists, that it is the same size and in the same location, and that it is a condition which continues unchanged since Judge Morgan's determination. Consequently, Employer contends, to find that the evidence proves a material change in conditions would be, in effect, a determination that Judge Morgan made a mistake of fact, which would only be an allowable determination if this were a request for modification pursuant to §725.310, which it is not. However, there is substantial evidence now before this tribunal which differs in quantity and quality from that which was before Judge Morgan, and which supports an independent positive determination as to the existence of the large opacity, and as to the resulting existence of complicated pneumoconiosis under the Act and regulations which would reflect a change in the applicable conditions of entitlement.

Contrary to the x-ray findings of Judge Morgan based on the evidence before him, three of the four x-ray interpretations admitted as new evidence in the instant claim establish the

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<sup>13</sup> D-3 consists of 1100 unnumbered pages in the record file.

existence of Category B sized large opacities and simple pneumoconiosis. Dr. DePonte recorded a 2/1 p/r with B sized large opacity; Dr. Hippensteel, 1/2, q/p with questioned B sized large opacity which he separately argued was not complicated pneumoconiosis; Dr. Robinette, 2/3, q/r with B sized large opacity; and Dr. Wheeler, 0/0, though he noted the existence of an oval 6x3 subapical mass which he described as compatible with conglomerate tuberculosis, rather than what he characterized as a less likely tumor. Why this would not have qualified and been recorded as a large category A or B opacity under the ILO U/C classifications is not explained, and this tribunal finds it is, at least, not inconsistent with the other three x-ray interpretations with regard to the existence of a large opacity of more than one centimeter visible by x-ray under prong (a) of §718.304.

Thus, the first prong in the requirements for proof under §718.304 of the existence of complicated pneumoconiosis includes proof sufficient to invoke the irrebuttable presumption that the Claimant is totally disabled due to pneumoconiosis, if the probative force of that evidence is not reduced. There is no new evidence of diagnosis by biopsy before this tribunal, though there was biopsy evidence before Judge Morgan upon which he based his finding of simple pneumoconiosis. The December 14, 2000, CT scan interpreted by Dr. DePonte and Dr. Wheeler established the existence of a posterior subapical right upper lung mass which Dr. Wheeler measured as 6 cm. wide and 3 cm. thick, and Dr. DePonte measured as 5x2 cm. Dr. DePonte described the mass as consistent with a conglomerate pneumoconiotic mass, but could not entirely rule out a lung carcinoma. Dr. Wheeler denied the existence of pneumoconiosis, but characterized the mass as well defined and compatible with “TB unknown activity probably healed.” That assessment suggests equivocation and is given little weight because there is no credible evidence that Claimant has or has had TB, and there is evidence that he has tested negative for TB. Dr. Wheeler’s reading, however, tends to reinforce the evidence of the existence of a large opacity and massive lesion.

Although Dr. Hippensteel speculated that the lesion was caused by granulomatous disease, and opined that the tests that were apparently administered were not totally reliable, he opined that TB was very unlikely, and Dr. Robinette essentially ruled it out based on those tests. This other evidence corroborates, and does not reduce the probative force of, the x-ray evidence of a large opacity greater than one centimeter under prong (a), despite different assessments by different doctors of its character. Together, this x-ray and CT scan evidence read as a whole establishes the existence of pneumoconiosis, which is a chronic dust disease of the lung. They also establish the existence of an opacity larger than one centimeter which would be classified as size A or B under ILO U/A standards. That opacity, in turn, establishes the existence of complicated pneumoconiosis under §718.304 for the purpose of invoking the irrebuttable presumption of total disability due to pneumoconiosis. The evidence characterizing the opacity as other than complicated pneumoconiosis does not rebut the proof satisfying the criterion under prong (a) of §718.304. Thus, there has been a change in the applicable conditions of entitlement which entitles the Claimant to a new determination of the merits of his claim on the record before this tribunal.

#### Complicated Pneumoconiosis as the Basis for Entitlement

The existence of coal workers' pneumoconiosis was established before Judge Morgan, and the existence of simple pneumoconiosis is reconfirmed, and essentially uncontradicted, by the evidence before this tribunal, as indicated above. The new evidence before this tribunal establishes the existence of an opacity larger than one centimeter, and thus legal complicated pneumoconiosis, under prong (a) and prong (c) of the applicable regulations, so that the Claimant is entitled to invoke the irrebuttable presumption of complicated coal workers' pneumoconiosis under §718.304.

The fact that Drs. Hippensteel and Robinette may have opined that the mass has not changed since 1998, is not dispositive of this claim, since the regulation does not mention any requirement for such change. Dr. DePonte's reading of the December 14, 2000, CT scan which identified a 5 x 2.5 cm. mass in the right upper lobe, supports, if it does not compel, a reasonable inference that a mass so far in excess of one centimeter, as revealed in a CT scan, would show as an opacity greater than 1 cm. on an x-ray, particularly because the locations of the mass by both methods are comparable, and the inference is reasonable and rational, in the absence of persuasive evidence to the contrary, that both the x-ray and CT scan images are of the same mass or opacity. Drs. Hippensteel and Robinette are B-readers; Dr. DePonte is a board-certified radiologist and B-reader. Dr. Wheeler is a board-certified radiologist and B-reader. Dr. DePonte is better qualified to diagnose x-rays than Dr. Robinette, a treating physician, and Dr. Hippensteel, although Dr. Hippensteel testified on deposition that he had extensive expertise with respect to the interpretation of thoracic CT scans. Dr. DePonte's measurements were roughly the same as those recorded by the other physicians. Thus, in each case, the doctors' identification of the existence of the large opacity is deemed reliable, though their characterizations of the opacity were disparate. Affirmative proof of clinical or medical complicated pneumoconiosis is not required under §718.304.

Although Claimant's pulmonary function study and arterial blood gas study results might not have shown any demonstrable increase in a pulmonary or respiratory impairment since 1998, as contended by Employer, such an increase is not a requirement under §718.304. Claimant's x-ray readings have shown an apparent change in conditions from 1/1 x-ray readings in Judge Morgan's decision to a 2/3 reading by Dr. Robinette in 2003. However, despite those changes, these readings only confirm the existence of simple pneumoconiosis, which was established previously, a chronic dust disease of the lung, which might now be more severe, but are not probative of a change in an applicable condition of entitlement, because the element of simple pneumoconiosis has previously been proved.

Dr. Hippensteel's various reasons for his opinion that Claimant does not have complicated pneumoconiosis are essentially beside the point, as they focus upon the existence of clinical, as opposed to legal, complicated pneumoconiosis, and do not reduce the probative force of the evidence which proves the existence of the large opacity under prong (a). Dr. Hippensteel opined that Claimant's normal pulmonary function test findings, including diffusing capacity, and resting and exercise arterial blood gas studies, are not indicative of progressive massive fibrosis referable to severe advance effects of coal dust inhalation. He opined that Claimant does not have any pulmonary dysfunction, and that the evidence is strongly contrary to a diagnosis of complicated CWP because complicated pneumoconiosis regularly causes impairment in pulmonary function. In his deposition, Dr. Hippensteel could not rule out a finding of simple

CWP, but opined that the large opacity was not complicated CWP because its calcification and pattern visible in the CT scans, as well as its failure to continue to grow, strongly favored granulomatous disease over CWP. Dr. Hippensteel opined that the small rounded opacities seen on Claimant's chest x-ray and CT scan could be from granulomatous disease such as tuberculosis, histoplasmosis, and sarcoidosis, that caused the development of a large lesion in his right upper lobe; that the lack of findings on blood tests to support histoplasmosis and sarcoidosis do not rule these diseases out; and that a negative skin test for tuberculosis does not rule it out completely, though tuberculosis, if untreated, would cause progressive changes in function which are not apparent in Claimant. Dr. Hippensteel's description of complicated pneumoconiosis or progressive massive fibrosis as a disabling disease routinely affecting pulmonary function is a description of a clinical disease with characteristics which are not essential to proof of the elements specified in §718.304. Dr. Hippensteel's opinion regarding Claimant's minimal pulmonary impairment was essentially consistent with Dr. Rasmussen's.

Dr. Robinette, however, who, like Dr. Hippensteel, is board-certified in internal medicine and pulmonary disease, diagnosed Claimant with complicated CWP with progressive massive fibrosis with a reduction of diffusion capacity secondary to the complicated CWP, and thus contradicts, and is deemed to offset, Dr. Hippensteel's assessment, to the extent that it is relevant under § 718.304. In reports and in his testimony at the hearing, Dr. Robinette noted that he has followed Claimant's health since 1987 and has seen him on a regular basis since the 1990s, which adds an element of persuasion to his assessment. Dr. Robinette opined that Claimant had complicated pneumoconiosis based on the evolution of a large opacity in Claimant's lungs, super-imposed on a background of pneumoconiosis. Thus, Dr. Robinette's opinion that a 1998 CT scan clearly demonstrated evidence of nodular interstitial disease consistent with silicosis and a six centimeter mass in the apical region of the right upper lobe with multiple foci calcification consistent with conglomerate pneumoconiosis, is consistent with and reinforces other evidence under prongs (a) and (c) of §718.304.

Dr. Robinette's opinion that there has been evidence of progression of radiographic abnormalities from 1/0 a general profusion of 2/2 with a category A mass, as well as interval enlargement of the pulmonary mass with associated fibrotic reaction, even though it had stabilized recently, ruled out the possibility of a malignancy, as well as contradicted Dr. Hippensteel's assessment. He also ruled out the possibility that Claimant had tuberculosis, histoplasmosis, sarcoidosis, and granulomatous disease based on several tests, x-ray readings, and Claimant's health, and thus was not equivocal in this regard like Dr. Hippensteel. His measurement based on a 2003 x-ray of a four to five centimeter mass with pleural thickening in Claimant's right upper lobe is evidence of the large opacity under prong (a), which was corroborated to some degree by his observation that there has been progressive scarring and distortion of Claimant's pulmonary parenchyma and the interval development of complicated pneumoconiosis over the past ten years prior to the report. His opinion that Claimant's complicated CWP was a direct consequence of his coal mining employment enhances the evidence of causation, just as his opinion that, while it is unusual for Claimant to have relatively normal lung function, it is not unprecedented, tends to neutralize some concerns expressed by Dr. Hippensteel. Thus, Dr. Robinette's assessment, which is reasoned and refers to objective evidence, is persuasive and tends to corroborate the proof under prong (a), although much of it is not essential to the elements of proof under the regulatory criteria specified in §718.304.

Dr. Dahhan's opinion that a rounded opacity seen in the lung was "highly suspicious" for bronchogenic carcinoma or possible old tuberculosis infection, and his inability to rule out the possibility of a large opacity is essentially equivocal and does not reduce the probative force of other evidence of such an opacity under prong (a). Dr. Dahhan opined that the Claimant's chest x-ray could be read for complicated CWP. But in concluding that Claimant had simple CWP, not complicated CWP, he simply relied upon the opinions of pathologists who earlier reviewed a biopsy of Claimant's lungs. From a respiratory standpoint, Dr. Dahhan opined that Claimant had no evidence of any respiratory impairment and/or disability as demonstrated by the examination and tests. Dr. Dahhan opined that the lack of abnormalities usually associated with complicated pneumoconiosis supported his opinion that Claimant did not have complicated CWP. However, his opinion was equivocal because of his identification of the suspicious large opacity but inability to rule out a large opacity. Most significantly, his opinion was directed to clinical complicated pneumoconiosis, rather than the standards specified in §718.304, except to the extent that he recognized a large opacity on x-ray, and thus his opinion does not refute the x-ray proof of an opacity of greater than one centimeter under prong (a), or the CT scan proof of such under prong (c). The evidence that was in the record before Judge Morgan is essentially superseded by the passage of time and new evidence with respect to a disease which is recognized as incurable and progressive. Consequently, that evidence before Judge Morgan is of little probative significance in the context of the whole evidentiary record before this tribunal which is probative of the existence of complicated coal workers' pneumoconiosis under the criteria specified in § 718.304.

#### Date of Onset

Since the Benefits Review Board affirmed Judge Morgan's denial on February 25, 2000, and the assessments of Claimant's condition with respect to complicated pneumoconiosis were equivocal or not definitive until the CT scans of December 14, 2000, provided reliable confirmation of the large opacity which is the basis for the finding of complicated pneumoconiosis and invocation of the irrebuttable presumption under § 718.304 in this case, the date of onset is found to be December 14, 2000, and payment of benefits should begin as of December 1, 2000.

#### Attorney's Fees

The award of an attorney's fee under the Act may be approved only if benefits are awarded. Because benefits are awarded in this case, the Act allows a fee to be charged for services of the attorney rendered to the Claimant in pursuit of this claim. A petition for an attorney's fee may be submitted pursuant to §§725.365 and 725.366 within thirty days of this order, with service upon all interested parties, including the Claimant. Opposition to the application may be filed within twenty days of receipt of service of the application.

## ORDER

The claim of Banner E. Marshall for benefits under the Act is granted, with benefits payable from December 1, 2000.

**A**

EDWARD TERHUNE MILLER  
Administrative Law Judge

**NOTICE OF APPEAL RIGHTS:** Pursuant to 20 C.F.R. §725.481, any interested party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision and Order by filing a notice of appeal with the **Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601**. A copy of the notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.